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ABSTRACT

Twenty-two members, drawn from different sectors of health service and educational systems of seventeen countries, comprised a working group of the World Health Organization (WHO) which was organized to consider the development of national systems of continuing education for the health professions. The working group first set out to define continuing education and health personnel. The concept of competence as the purpose of continuing education was then discussed, and existing patterns of continuing education in all the countries were reviewed. The working group accepted the systems approach to continuing education as the most advantageous and endorsed a model which contains a seven-step process. (These seven steps include identifying problems, establishing standards, analyzing performance, determining causes, establishing educational programs, reviewing performance, and moving or recycling.) To accomplish this approach, the group delineated several organizational and educational tasks. In conclusion, the working group reviewed and endorsed the specific recommendations made to the WHO in 1973 by the Expert Committee on Continuing Education for Physicians. (BM)

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Continuing Education of Health Personnel

Report on a Working Group

Dublin
18–21 October 1976

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Note

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This report is also available in French and Russian.

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1. INTRODUCTION

It has become increasingly recognized that the advancement of standards of health care depends, among other factors, on the acceptance by health professionals of a lifelong commitment to continuing learning. Knowledge and skills acquired during basic or specialist training may be rendered obsolete by new scientific or technological developments; changing patterns of disease and disability in the community may make new demands on professional skills, as may developments in the health care delivery system; while established knowledge and competence of continuing value may be neglected and underutilized. Clearly, personal commitment by health personnel will not in itself accomplish very much unless appropriate learning opportunities are provided. At the same time, it has become evident that the creation of such opportunities on an adequate scale raises complex organizational and educational issues.

Following the publication in 1973 of the Report of a World Health Organization Expert Committee,[a] the Twenty-Seventh World Health Assembly called upon Member States to consider as a matter of urgency "the development of national systems of continuing education for the health professions, based on national and local needs and demands, integrated with health care and educational systems, with full utilization of the resources of universities and schools of health personnel".[b] The same resolution requested the Director-General to give all possible assistance towards the attainment of this objective. In response to the resolution, the Regional Office for Europe of the World Health Organization, with the collaboration of the Government of Ireland, convened a Working Group at Dun Laoghaire from 18 to 21 October 1976 with the task of reviewing the state of continuing education in the European Region and considering what steps were needed to further its development.

The Working Group consisted of 22 members, drawn from different sectors of the health service and educational systems of 17 countries. At the formal opening session they were welcomed by Dr B. Hensey, Secretary of the Department of Health of the Government of Ireland. He drew attention to the relation between the quality of health services and that of its personnel. The remuneration of personnel accounted for the greater part of the money spent on services; how the rest was spent depended very much on the quality of the personnel. Governments were therefore very much concerned

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[a] WHO Technical Report Series, No. 534, 1973 *(Continuing education for physicians)*

[b] WHO Official Records, No. 217, 1974, Resolution WHA27.31

to maintain and improve the competence of personnel, and in this respect the topic covered by the Working Group was particularly apt. Continuing education had to be seen as an integral part of health manpower development, directed at increasing the effectiveness of every category of health worker and not only of the medical profession.

The Director of the WHO Regional Office for Europe, Dr Leo A. Kaprio, was represented by Dr J. Gallagher, Regional Officer for Education and Training. In his opening address he referred to the contribution which Irish medical education had been making for many years to the medical manpower of many countries throughout the world. The recent establishment by the Minister of Health of a Council for Postgraduate Medical and Dental Education and Training, with a major responsibility for continuing education, showed that the Irish health authorities recognized the value of education in maintaining and improving the quality of health services. Continuing education was seen to be as much a part of a health professional education system as basic and specialist education. Health and education authorities in many countries were seeking the organizational and technical means whereby the different phases of health professional education could be integrated and more effectively oriented towards meeting social health goals. He felt sure that the Working Group, in which half the countries of the European Region as well as the major health professions were represented, would indicate to the WHO Regional Office for Europe and the Member States of the Region the most effective means whereby continuing education could be developed as a service for health administrations and the health professions.

Professor E. O'Dwyer was elected Chairman of the Working Group and Professor F.M. Martin, Rapporteur.

2. DEFINITION OF CONTINUING EDUCATION

In its opening discussion, the Working Group was concerned to identify as clearly as possible the scope of its task. This involved defining both "continuing education" and "health personnel". As regards the latter definition, the Working Group went beyond the terms of reference of the 1973 Expert Committee, and made it clear that it followed the lead of the World Health Assembly in taking account of the needs of all health personnel, such as nurses, social workers, health service administrators and environmental health personnel, as well as physicians. Given that broader definition of personnel, the Working Group accepted an appropriately modified form of the Expert Committee's view of continuing education as the training that an individual health professional undertakes after the end of basic professional education – or of any additional education for a career as a generalist or a

specialist – to improve competence as a practitioner, and not with a view to gaining a new qualifying diploma or license. The Working Group was also of the opinion that, although the reference in the WHA resolution to maintaining and improving the competence of health personnel in delivering health care as the primary purpose of continuing education was clearly intended to incorporate a concern for disease prevention as well as delivery of care, it would be as well if that emphasis on the preventive as well as the therapeutic aspects of medicine were made explicit.

3. THE CONCEPT OF COMPETENCE AS THE PURPOSE OF CONTINUING EDUCATION

The concept of competence was discussed at some length, and the Working Group endorsed the emphasis of earlier deliberative bodies on the maintenance and extension of professional competence rather than merely the acquisition of knowledge. This is not to say that the Group opposed "knowledge" to "competence" and rejected one in favour of the other. Rather, the Group recognized the value of the acquisition of new knowledge in the course of continuing education, to the extent that it could be shown to contribute to the enhancement of competence. The emphasis on competence meant that some means was needed whereby professional performance which fell short of acceptable standards could be identified, that education and training should focus on inadequate performance, whether in practice or administration, which could be remedied, and that mechanisms should be developed for evaluating the effects of education and training in terms of performance in delivering health care rather than merely by tests of knowledge.

4. EXISTING PATTERNS OF CONTINUING EDUCATION

The members of the 1973 Expert Committee on continuing education, drawing on the results of an incomplete questionnaire survey of Member States, had commented that what was then available under the name of continuing education was neither continuing nor education, and might better be called episodic instruction. They remarked on the failure of programme objectives to take into account the needs of the health services, the uncertain basis on which educational priorities were determined, the lack of variety in educational methods and the general absence of evaluation of effectiveness.

In preparation for the present Working Group, the Regional Office for Europe in 1976 carried out a new study in nine European countries in order to obtain base-line information on the current state of continuing education for health personnel; this information would, among other things, permit an evaluation at a later date of progress in this field. However, the study dealt almost exclusively with the continuing education of physicians because this is much more often the subject of legislation and official regulation than that of the other health professions. For the present Working Group, surveys of the position regarding nursing, social work and environmental health had been provided by those members associated with continuing education in these professions. The following sections summarize the findings of the study and the information made available on the other health professions.

4.1 National policies on continuing education in eastern Europe

In eastern Europe continuing education of health personnel is a government responsibility. Ministries of health delegate the organization of official continuing education programmes to central educational organizations such as in Czechoslovakia, the Institute for Postgraduate Education in Medicine and Pharmacy and the Institute for Postbasic Education of Health Personnel, and in Hungary, the Institute of Postgraduate Medical Education in Budapest. These central institutes draw on the resources of medical faculties, medical research institutes and other qualified institutions providing health services. Specialized branches of academic medical societies and health workers' trade unions are also involved in continuing education. In Czechoslovakia, each of the twelve regions in the country has its own regional institute of national health, with a particular department responsible for organizing the various types of continuing education at the regional level. These departments cooperate closely with the central educational institutes, local health authorities and regional and district specialists. The specialists are usually heads of hospital departments, polyclinics and other health care facilities, and are responsible for arranging the various educational programmes at the local level.

In all eastern European countries, continuing education is obligatory for health workers. Thus, in Czechoslovakia, doctors who are heads of hospital departments polyclinics and other health care facilities, are required to attend centrally-organized cyclical courses every three years. In Hungary, all doctors are required to spend two months in a registered hospital every three to five years. All the expenses of such courses are met by the State, and replacements for the doctors are also provided. The personal record of every doctor, which is maintained at central level, contains information on compliance with these educational requirements. These records are reviewed by the heads of health institutions at regular intervals and discussed with the staff. The continuing education programme for each individual

is planned for a specific period, for example, in Czechoslovakia, for the ensuing two-year period, in the light of the needs of the institution and the special wishes of the individual.

In Yugoslavia, continuing education of health personnel is regulated by legislation pertaining to the constituent Federal republics, under which medical practitioners and other health professionals are required to take continuation training courses organized by the major medical schools, in accordance with suitable programmes. In its organization, continuing education of medical personnel is strongly supported by the professional medical bodies and associations of other health professionals. The costs of continuing education for health personnel are borne by the establishments employing those receiving the training.

4.2 The roles of professional associations

In the other European countries surveyed, where there are no government controlled programmes of continuing education, professional associations are responsible for organizing such education. In Austria, the Netherlands and Norway, this role of the medical associations is formally recognized. However, there is no systematic coverage of the membership of associations.In Norway, general practitioners who complete an approved programme of continuing education over a period of five years receive a special title and are entitled to charge higher fees. In the Federal Republic of Germany, all doctors must be able to prove that they have taken part in continuing education in accordance with the regulations issued by the *Landesärztekammern*. In other countries, there are neither material incentives to induce members to undertake continuing education nor penalties for those who fail to do so. In all the countries, the professional associations (medical, nursing, dental and others) draw on the resources of professional training institutions, the larger hospitals and State agencies. They also receive substantial support from the pharmaceutical industry by way mainly of financial contributions and audio-visual material.

In the Federal Republic of Germany, academic specialist associations and other professional medical associations, as well as large hospitals and group practices, organize continuing education activities for physicians. Most of the *Länder* medical councils have special academies for continuing education. The German Senate for the Continuing Education of Physicians, an institution of the *Bundesärztekammer* (Working Group of the Federal German Medical Chambers) coordinates the activities of the *Landesärztekammern* in the field of continuing education. For the nonmedical health professions, professional associations as well as numerous other institutions and organizations provide a wide range of possibilities for continuing education. The *Bundesärztekammer* organizes an annual congress of the auxiliary medical professions, mainly for medical assistants and technical assistants.

In Italy, the Italian Centre for Medical Training, San Remo, carries out activities mainly focused on the continuing education of health personnel. It is concerned especially with the collection, evaluation and possible utilization of national and international studies and of data on both adult education technology and the responsibilities of specific categories of health personnel. The results of these surveys are periodically published in a journal and in other documents and working papers issued by the Centre. The Centre also organizes meetings, seminars and courses. Another centre, at Florence, is responsible for the continuing education of nonmedical health personnel of the Tuscany Region.

In Norway, the Norwegian Medical Association contributes the equivalent of $800 000 each year for continuing medical education and for the maintenance of two university institutes of general practice, at Oslo and Bergen, which organize continuing education for general practitioners. Doctors obtain tax relief on their expenditure on continuing education.

In the Netherlands, by virtue of a 1975 law, the Royal Dutch Medical Association is required to organize continuing education for family doctors, and academic specialist associations are responsible for the continuing education of specialists. These associations are required to organize such post-academic education in collaboration with the universities. A recently appointed commission will have the task of making arrangements for this education. The continuing education of general practitioners and specialists will take place at three levels; central, e.g., the University of Leiden Boerhaave Course; regional, with the cooperation of the eight medical faculties; and local, with the assistance of local hospitals.

In Switzerland, cantonal professional organizations and specialist societies, as well as medical faculties, are responsible for continuing education. Expenses are met from participants' fees, from contributions by professional organizations and, to a substantial degree, from the pharmaceutical industry.

4.3 Shortcomings in educational planning

There is no indication from any of the countries surveyed that continuing education is planned in the strict educational sense, i.e., that specific objectives are related to the ascertained educational needs and to the deficiencies of health personnel vis-à-vis their functions and tasks in the health services. The outcome of continuing education programmes is not assessed in terms of changes in the professional behaviour of course participants or against health service related criteria. However, all countries report that the topics chosen for continuing education reflect current interests and needs in the health and medical care services. The introduction of new treatments and programmes, e.g., screening programmes in sickness insurance schemes, is usually preceded or accompanied by service-oriented educational activities.

4.4 Lack of health service indicators of inadequate professional performance

There is equally no suggestion that any of the health administrations concerned monitor or evaluate the performance of health service personnel in order to determine their needs for continuing education. Health and continuing education authorities in a number of different countries are discussing the possiblity of developing indices of quality of care which would serve as indicators of the need for, or the effects of, continuing education, but no such indices have yet been established. None of the countries surveyed reported the use for continuing education purposes of such monitoring mechanisms as peer-review, medical or nursing audit (operational audit, clinical audit, prescribing audit), self evaluation, analysis of hospital admissions and length of stay in hospital, or analysis of maternal mortality and perinatal mortality. There is no evidence of the existence of mechanisms in health insurance schemes for monitoring the quality of care and the competence of physicians in order to encourage doctors to maintain their competence. In the Federal Republic of Germany, the official health insurance funds have begun to collect operational and experimental data on certain aspects of hospitalization and on perinatal and maternal mortality, and these are being taken into account in continuing medical education.

4.5 Teaching methods and media

As also indicated in the report of the Expert Committee, the evidence shows that continuing education programmes tend almost entirely on conventional teaching methods which do not often involve participants actively in the learning process. The evidence is overwhelming that "continuing education" is concerned with the transmission of information and knowledge and not with competence. When modern media are employed, such as television, closed-circuit television, tape-cassettes, video-tapes they do not seem to permit interaction between "teachers" and "students", nor are they used for evaluating competence. Media are rarely evaluated for their effectiveness, although occasionally professional bodies assess films for their value in continuing education and maintain a list of those which have been found of value. Neither in eastern nor western Europe does it appear that those who plan or carry out continuing education have received any special training in educational methods.

4.6 Major deficiencies of existing patterns of continuing medical education

The Working Group was of the opinion that the detailed findings of this study, here reported only in the briefest outline, clearly identified a number of serious deficiencies. The selection of priority areas for continuing education

is generally unsystematic, and rarely, if ever, arises from joint discussion between the educational institutions, the health administration and the practising professionals. Imaginative approaches to the educational process are unusual. Although forays into educational technology are not uncommon, the lecture remains the dominant teaching method, and the emphasis is almost invariably on imparting information rather than encouraging active learning. Although expertise in the relevant subject matter is an essential prerequisite for contributing to continuing education, the value of educational expertise seems never to be considered. Evaluation and systematic feedback have at present little or no place in European continuing medical education. Finally, while it would be logical to organize continuing education so that the different categories of health personnel who work together could be trained together, such an arrangement is very unusual.

4.7 Continuing education of nursing personnel

As already pointed out, the study dealt mainly with continuing medical education and did not provide an adequate basis for assessing the state of continuing education in the nursing and other health professions. As regards nursing, the position seemed to be that, apart from the eastern European countries, continuing education was not yet the subject of legislation, as continuing medical education tended to be. Voluntary nursing associations, however, were increasingly active in the field, and several European national nursing associations had considerable influence on educational programmes for all categories of nursing personnel. Members of the Working Group knew of well-constructed programmes in several countries.

However, while progress had been made in postbasic nursing education, continuing education as such had not been developed to anything like the same extent. Nevertheless, there was a widespread recognition among the leaders of the nursing profession of the need for continuing education for all health workers engaged in nursing.

Certain difficulties seemed particularly to stand in the way of continuing nursing education. Thus, nursing personnel have not been prepared, either by the general education system or by their basic professional education, to treat education as a continuous process on a "lifetime" basis, and have not been prepared to play an active part in their own education or to take responsibility for it themselves. They tended to consider their basic training or subsequent specialized education as being sufficient. They were generally poorly informed on research trends in nursing care and on the advances made by some sectors of their profession, and this tended to result in perpetuation of the *status quo*.

Generally, there was no established right to continuing education and many employers neither conceded the principle of such education nor made budgetary provision for it.

Where legislation on continuing education existed, it placed much more stress on quantitative (number of course hours taught) than on qualitative aspects (the development of professional skills).

With few exceptions, nurses rarely had the qualifications for planning and coordinating continuing education and for providing teaching for nursing personnel who were themselves often highly qualified and very experienced. This led to a situation where medical practitioners were often called upon to provide such education. They, in turn, were rarely trained in teaching methods and could usually provide only medical information which did not meet the education and training needs of nursing personnel.

There had been little research into the problem of establishing the real requirements for continuing nursing education. Methodologies had to be developed which could serve to identify continuing education requirements for different types of nursing personnel so that realistic goals could be set and appropriate content, teaching methods and evaluation instruments developed.

4.8 Continuing education of social workers in health services

It is becoming increasingly recognized that social workers have both actual and potential roles in a variety of health service and related settings, and that a generic, i.e., nonspecialized basic training cannot provide all the knowledge and skills required in the different areas of social work practice. It is also realized that specialization in certain areas of health-related social work is valuable in terms of skilled service.

At the same time, the increasing professionalization of social work has reduced the influence which medicine formerly had in the basic training of medical and psychiatric social workers, so that generically trained social workers who come to practise in health care settings have often had little opportunity to become familiar with medicine or health care in general.

Perhaps most importantly, medical and social workers experience difficulties in collaborating with one another, and this compromises the quality of the services which, e.g., a health centre could provide.

While there are very powerful arguments against a return to older forms of "segregated" social work training, there is equally a strong case for moving towards new patterns of specialized training, and for developing a wide-ranging programme of continuing education for qualified social workers.

Existing generic courses provide a basic qualification for practice, but it is likely that a significant proportion of qualified social workers will, after some experience, elect to embark on specialized postbasic training. Health-related social work, which requires for its effective practice both a considerable understanding of medical problems and familiarity with the styles of work and of relationships that are characteristic of health care settings, is coming to be regarded as an essential area of specialization.

Social work has moved decisively away from the assumption that, once a professional qualification has been acquired, no further training is necessary. Those working in health centres or hospitals recognize the need to keep in touch with changes in medicine and medical care, as well as with developments in social work knowledge and skills, and to contribute both as learners and teachers to the effectiveness of the health care group to which they belong.

4.9 Continuing education of environmental health personnel

The needs and opportunities for the continuing education of environmental health personnel do not differ basically from those for other health service personnel. The recent upsurge of concern about environmental problems has stimulated demand for continuing education in health and human ecology from professional groups, mainly engineers, architects and lawyers, as well as doctors, whose duties call for an understanding of the health and ecological effects of industrialization and technology.

Technological innovations, changes in emphasis, e.g., from a narrow focus on health to a broader concern with human ecology and the conservation of resources, and new roles in administration and management for technically trained personnel, make educational demands which are met mainly by conventional forms of educational group activities organized by universities, technical colleges, professional associations, and employers, including governments and government agencies.

New manpower problems of environmental health services and corresponding educational responses were among the topics discussed at a joint meeting[a] organized by the WHO Regional Office for Europe and the Association of Schools of Public Health of the European Region in 1975.

A Conference[b] organized by the Centre for Educational Research and Innovation of the Organisation for Economic Co-operation and Development (OECD) in 1974 was concerned, *inter alia*, with recurrent education. It recommended that the principle of recurrent education should be developed "as a long-term strategy for the future of environmental education" and that "in the immediate future, educators, professionals, and decision-makers should have better opportunities for retraining and for expanding their environmental knowledge and skill. This could be achieved by developing a flexible organization for both systems of education and work".

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[a] **WHO Regional Office for Europe.** *Training manpower for health administrations:* report on a Working Group, Brussels, 9–11 September 1975. Copenhagen, 1976, pp. 13–16 and 21–22

[b] **Organisation for Economic Co-operation and Development.** *Environmental problems and higher education.* Paris, 1976

The Working Group was reminded of the potential value to health of the reduction or elimination of environmental hazards, and of the widely held conviction that, at least in developed industrialized societies, improving the quality of the environment would contribute much more to health levels and the quality of life than efforts to further develop personal health services. Continuing education would have a major role to play in this respect.

5. A SYSTEMS APPROACH TO CONTINUING EDUCATION

The Working Group was convinced that major advantages would accrue from the adoption of a systems approach to the planning of continuing education, as advocated in the World Health Assembly resolution. It is assumed that the general features of such an approach are by now sufficiently familiar for any detailed account to be unnecessary. It represents an attempt to break away from old established habits of thinking and planning in a piecemeal fashion. Instead, an attempt is made to formulate a problem as a whole; objectives are defined and both available resources and likely constraints are identified. Alternative courses of action can then be set out and their probable consequences considered in advance. There is a strong emphasis on providing objective data in order to place decision-making on a firmer foundation, and on evaluation in the sense of comparing results actually achieved with the objectives specified. In the context of continuing education for health professionals, the systems approach may be seen as offering a more powerful means of determining the priorities to be assigned to possible goals, of assessing the effectiveness of educational processes, and of progressively improving that effectiveness. The assumption underlying the use of the model suggested here is that the primary purpose of continuing education is the improvement of professional competence in the service of better health care. The Working Group recognized that this was in itself a value-judgment, a statement of what "ought" to be, but believed that the application of rational planning methods must ultimately be contained within a framework of such judgments; in the present case, the Working Group did not believe that any other "purpose" for substantial investment in continuing education could be morally justified.

The model which the Working Group endorsed was summarized in a paper contributed by Dr George E. Miller, and places its principal emphasis on investigating and meeting educational needs. These needs, it is argued, cannot necessarily be inferred either from the views of educators or from those of practitioners as to what ought to be taught. There are seven steps in the process.

(1) *Identifying problems.* The first task is to list the major health care problems and service deficiencies encountered in a given setting, defined at any one of a number of different levels – national, regional, local or that of the individual practice. This step implies the existence and use of a range of methods for the identification of problems on the part of consumers, practitioners and administrators of health care services. These would normally include the use of routine morbidity statistics, the analysis of practice records and different types of community health survey as well as various forms of audit, and assessment of professional competence, including self-evaluation. A perfect order of priorities of health care problems will not automatically follow, but may involve certain trade-offs between the prevalence and the severity or seriousness of the various problems.

(2) *Establishing standards.* Within the selected setting, acceptable standards of care must be established for the health problems to which top priority has been given. The educational process can have little chance of success unless agreement as to the standards to be aimed at can be reached between experienced practitioners and specialists in the relevant field. Neither group can carry out the task on its own. Standards in this context should not be seen as limited to the exercise of clinical judgment and skills, but should also apply to the contributions of nonmedical members of the health care team. Standards, it should be added, are not absolute; their validity needs to be determined in practice, and new developments may cause them to be reviewed from time to time.[a]

(3) *Analysing performance.* This involves the systematic review of current levels of performance by examining, e.g., routine public health data (though these are rarely sufficiently sensitive or thoroughly analysed to be very useful), scrutiny of records, patient surveys, self-evaluation, or examinations designed to probe specific components of competence. The object is to compare actual performance with the standards previously agreed upon. If performance does not fall short of the standards, no further steps are required as far as the particular health care problem is concerned. Where discrepancies between criteria and actual achievement are apparent, however, the subsequent steps are necessary.

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[a] It may sometimes be neither feasible nor realistic to define a specific standard. An alternative approach, advocated within the Working Group, is then to review the performance of different individuals or teams, to compare outcomes and to analyse the reasons for significant differences. Such an analysis can then provide a basis for corrective educational or other measures. An approach of this kind, in effect, takes the place of steps 2, 3 and 4.

(4) *Determining causes.* The cause of disparity in any given case may be self-evident, but is more likely to emerge from discussion between educators and practitioners. Sometimes failure may have resulted from the establishment of a standard which was manifestly unrealistic in terms of available knowledge and management techniques, sometimes from the unsatisfactory organization of the health care system. The task is to pin down those instances in which the shortcomings can be attributed to causes which are in principle remediable by educational means. Such causes would include not only lack of formal knowledge or technical skills or their misuse, but also poor management of resources.

(5) *Establishing educational programmes.* An educational need having been identified as a cause of inadequate health care, an educational programme should be designed to meet that specific need. It may be that ignorance of newly available knowledge is the root cause of failure to achieve agreed standards; if so, opportunities must be provided for that knowledge to be acquired and used. A very large part of present-day continuing education is offered on the implicit assumption that keeping up to date with new advances in knowledge and techniques is the only important objective. While the value of learning new ideas and methods is in no way in question, and while practitioners are always likely to be highly motivated to take advantage of opportunities to do so, it is worth adding that failure in this respect is less often the cause of suboptimal performance than might be inferred from the spectrum of continuing education opportunities. In setting up educational programmes, therefore, it will often be necessary to tackle other causes by other means. Unsatisfactory performance may be attributable to insufficient or inappropriate use of available knowledge; if so, the emphasis should be on refining skills in problem solving. It may be attributable to poor management of resources, e.g., when the physician is unable to see all his patients because he is doing what others could do equally well; continuing education should then deal with practice management skills and with attitudes towards other members of the health team. It may be attributable to apparent lack of cooperation on the part of patients, in which case continuing education might address itself to the improvement of skills in communication. If it is the administration and/or management of the health care service which is at fault, the educational shortcomings of administrators and managers will need to be dealt with.

(6) *Reviewing performance.* After completion of the educational effort, an attempt is made to assess its effectiveness by the reexamination, after a previously agreed interval, of the performance of the target group or groups. This evaluation phase is, of course, of critical importance, though, as indicated earlier, it is generally neglected in continuing education programmes. The methods of evaluation may in some instances be extremely

simple, involving perhaps no more than a review of patient records. They may, however, need to be quite subtle and complex, especially if evaluation is ever to progress from the measurement of immediate impacts to the assessment of longer-term outcomes. There is some danger in concentrating exclusively on the comparatively straightforward task of assessment based on recognized biomedical tests, to the neglect of wider aspects of patient wellbeing. The health and welfare of patients should not be interpreted simply in terms of the sum total of the results of a series of clinical and laboratory tests; in any long-term evaluation of the results of continuing education, therefore, it may be desirable to employ psychosocial methods for directly assessing wellbeing.

(7) *Move on or recycle.* If the desired standard has been achieved, it should be possible to move to the next health care problem identified in the critical diagnostic phase and to go through the same series of steps with that problem. If there has been a failure to achieve the objective assigned, the reason for this should be determined and a further attempt made to bring about change.

Among the essential features of this method are its emphasis on the systematic identification of needs and selection of priorities, and the careful designing of educational programmes so as to remedy recognized deficiencies. It requires the active involvement of practitioners at every step, as joint participants rather than passive recipients. Any risk of developing an overmechanistic, self-regulating, or more or less closed system, can be avoided by imaginative application in the context of a lively professional environment, in which several different educational and other bodies are involved.

In many countries of the European Region, some forms of continuing education for health personnel are in use; in certain countries, they are centrally organized and on a quite substantial scale, in others more casual and spasmodic, in yet others little more than embryonic, but nowhere, in the view of the Working Group, do they meet even a few of the requirements of the systems approach outlined above. Yet, given the number of groups and interests involved in continuing education for health personnel, it is difficult to imagine the total implementation of a new and comprehensive plan of continuing education based on the rigorous use of the systems approach. The Working Group, in giving its full endorsement to this distinctive philosophy, was inclined to see its implementation as a strategic objective. It is not likely to be achieved in full immediately, but the Working Group judged it to be of the highest importance that ministries, educational institutions and professional associations should move as rapidly as possible towards ensuring that their activities in the field of continuing education follow the pattern outlined here. Any proposed new development should be critically examined from this point of view.

6. ORGANIZATIONAL TASKS

While organizational arrangements cannot in themselves solve functional problems, they can serve to make solutions easier or for that matter more difficult to achieve. For an approach to continuing education such as that recommended in this report to be carried through, certain organizational developments are an essential prerequisite. In view of the wide variation in political, health care and educational systems within the European Region, no single scheme or pattern can be appropriate under all circumstances. It is possible, however, to specify just what any new organizational arrangements must be able to accomplish.

Responsibility for continuing education cannot be given only to the health administration or only to the educational bodies. Formal links must be created between the health care system, the educational institutions of the health professions, and the practising professions themselves. The resulting structure must inevitably have some coordinating functions, but should also be able to do a great deal more than bring together the views and activities of participating bodies; it should indeed be responsible for planning and allocating educational resources.

An interesting example, which meets most of the organizational requirements, is to be found in the United Kingdom; here, in addition to the national advisory groups, the Councils for Postgraduate Medical Education, there are also regional organizations with direct responsibility for operating programmes in continuing education, each under a Regional Postgraduate Dean (who is appointed by the university associated with the region). The Dean normally acts as Chairman of the Regional Postgraduate Committee and is responsible for seeing that suitable courses are arranged within the university and at the District Postgraduate Medical Education Centres. The Dean and his clinical tutors at District Postgraduate Medical Education Centres are responsible for the planning of educational programmes, but there is no separate organization involved in the systematic planning of programmes or their evaluation against health service performance criteria. The United Kingdom system is purely medical; it makes no provision for the continuing education of health service personnel other than physicians. However, other health professions, such as nursing and midwifery, do have arrangements for continuing education, even though these are not exactly parallel to those for the medical profession.

6.1 Functional criteria of a continuing education system

If continuing education is to be promoted, the organizational structure which is developed must:

(a) be responsive to changing patterns of health care needs, and the demands and needs of health service administrations;

(b) be responsive to advances in knowledge and technique in the relevant disciplines;

(c) be in touch with thinking in all the relevant professions;

(d) be able to encourage participation in continuing education;

(e) be able to call upon a wide range of educational resources; and

(f) take an active interest in monitoring and evaluation.

Yet, even for a single profession, a relatively satisfactory structure is not – as was suggested at the beginning of this section – in itself a sufficient guarantee that the resulting programmes of continuing education will be systematically geared to meeting community health care needs. This requires a crucial contribution from the health service administration, whose task it should be to identify those needs. This is the vital first step in the cyclical process described earlier; the necessary input to the planning process should come from the health service administration through its interpretation of routine health statistics, the carefully evaluated findings of special epidemiological and social enquiries, and the monitoring of health manpower. These tasks might be conducted by the health care agency itself, but some would more commonly be contracted out to university departments or research institutes, and others might be undertaken by, or in co-operation with, professional associations. The organization, in short, must not only be responsive but must have something substantial to respond to.

Responsiveness to advances in knowledge and technique perhaps presents fewest problems. Indeed, the Working Group observed somewhat critically that, in many countries, there was, if anything, an excessive preoccupation in existing systems of continuing education with new advances. At any rate, it seems fair to assume that the involvement of advanced teaching centres will ensure that these aspects of continuing education are not neglected. Specialist associations and learned journals also usually take a lively interest in new developments, and will no doubt continue to make this their own principal contribution to continuing education.

Effective links with health professionals in general, and not only with their more distinguished academic representatives, are essential. This clearly requires some form of regional or even local structure. If the links exist only at national level, they are likely to be over-formal and this may raise serious problems. The significance of these links, in fact, arises from the need to involve practitioners deeply in the entire educational process. The

difficult and psychologically demanding concept of continuing education espoused by the Working Group, with all that it implies as to openness and readiness to recognize one's own limitations, can succeed only if practitioners see themselves as active partners in a continuing process of self-criticism and self-learning rather than as passive recipients of the wisdom of others.

6.2 Responsibilities of health personnel

For practitioners to participate in continuing education, they must not only be personally committed and motivated, but must also have the opportunity to do so. They should also have reason to believe that the time and effort expended in improving their professional competence will not be to their disadvantage in the pursuit of their careers.

A fee-for-service basis of remuneration for medical practice is often considered a barrier to continuing education for physicians. It is not sufficiently realized, however, that the real problem lies in the conventional view that education requires the practitioner to absent himself from his place of work, and can take place only in a formal didactic setting. The improvement of professional competence on the part of fee-for-service practitioners is as much a matter of "on-the-job" or in-service learning, in a great variety of ways, as it is for salaried practitioners, the cost to a health administration may be even less than that for conventional forms of education. For those who work as salaried employees of a State, region or municipal health service, or as regular contractors to such a service, however, there is everything to be said for including in the standard conditions of service a contractual right to devote an agreed number of working hours to continuing education. Such a right does, of course, already exist in a number of countries of the Region.

6.3 Role of the universities

Continuing medical education has generally been provided mainly by the personnel of university medical centres and teaching hospitals and in particular those working in postgraduate centres and advanced specialist institutes. Their value and significance scarcely needs to be emphasized. However, the concept of continuing education adopted by the Working Group points to a need for a broader approach to the skills required. Even for medical practitioners, the Group's emphasis on improving standards of health care as the key objective means that other types of expertise may need, according to the problem in hand, to be drawn upon from time to time. One development which the Working Group welcomed for its relevance to continuing education is the establishment within medical schools of departments of general practice; these maintain active links with family doctors practising in the region and work with them on what are mutually agreed to be important issues in continuing education.

Many of the skills that may be of value, however, are often located outside faculties of medicine. Departments of psychology, social science, and management studies may all, from time to time, have a significant contribution to make to the solution of specific problems in continuing education. These may involve, for example, relations within the health care team, communication between doctors or nurses and patients, or the replanning of work patterns within a health care setting. Departments of education often have a great deal to offer in helping teachers in continuing education (or other teachers of professionals for that matter) to acquire the skills required to encourage active learning.

Health professionals other than physicians are on the whole less well placed to draw upon the resources of the higher education system for their continuing education. Nevertheless, university departments of nursing studies and of environmental studies are becoming increasingly well established; university departments of social work and social administration are also quite numerous, even though most have only recently begun to recognize their responsibilities for postbasic education. With regard to multidisciplinary training, the example of the King's Fund College in the United Kingdom was cited. This provides continuing education in management so that joint training in communication and in individual managerial skills takes place. Perhaps least well served in this respect are senior health administrators, irrespective of their basic professional backgrounds; the WHO Regional Office for Europe has begun discussions with some national administrations on this problem.

6.4 The health team as the learning unit

The Working Group was conscious of the fact that educational planning for the professions was almost invariably undertaken on a monoprofessional basis. Physicians may contribute to the continuing and basic education of nurses and occasionally to that of social workers, but the reverse is virtually unknown. Opportunities for joint learning on an interprofessional basis rarely exist. In view of the importance now universally attached to the concept of the health care team, it seemed anomalous that the team was not recognized as a unit for learning purposes.

6.5 Educational evaluation

The last of the Working Group's requirements that a structure for continuing education should meet was that it should be capable of monitoring and evaluating its own activities. Evaluation is talked about a great deal, but actually undertaken comparatively infrequently. There are real enough methodological difficulties, but there are also equally important and generally unacknowledged psychological resistances. Evaluation is impossible unless

objectives are clearly specified, but planners and practitioners in all spheres are often reluctant, and sometimes unable, to formulate their goals in such a form that success or otherwise in attaining them can be assessed with precision. The whole concept of continuing education advanced in this report, however, requires a commitment to clarity, to explicitness and to systematic assessment of impact and effectiveness. Many good evaluation methods, including some intended for self-evaluation, exist; others have still to be developed. The old-established belief that examinations that measure the ability to recall memorized information are an adequate substitute for methods of assessing competence must be abandoned. Personnel capable of planning and carrying out evaluation procedures are therefore essential in any system of continuing education.

7. EDUCATIONAL TASKS

The approach to continuing education adopted by the Working Group involves not only certain organizational arrangements but also a distinctive view or philosophy of the educational experience. Although this view is implicit in the content of this report, it should also be stated explicitly, not least because it has some definite practical implications.

Those engaged in planning or carrying out continuing education have continued to place the major emphasis on the instructional aspect of education, and have relied mainly on the formal lecture as the means of conveying information. The Working Group did not consider that this was a bad form of continuing education, but rather that it was often inappropriate, especially if it is agreed that the principal aim is to improve standards of health care by promoting professional competence. It is learning rather than teaching that needs to be emphasized. The foundation of learning is self-awareness and self-criticism. Ideally, the professional, although formally qualified, must be sensitive to his own limitations and be prepared to recognize them openly rather than conceal them. Those who are substantially involved in continuing education must be competent to work together with their "students" in a variety of educational settings which permit active learning and problem-solving rather than passive absorption of information. The more advanced the "students", the more must education turn its back on didacticism and dogmatism, and the more should the educators concentrate on creating opportunities for self-learning. Some of the difficulties that have to be resolved if this approach is to be fruitful come within the realm of group dynamics rather than of pedagogy in the narrow sense.

It will not be easy to bring about such changes. Continuing education does not take place in a vacuum, but in an environment inevitably influenced

both by the styles of basic professional education and by the values of the health care system. These have a powerful effect on the consumers of continuing education, influencing many of their motives, attitudes and expectations. Clearly, continuing education of the kind discussed here will achieve most when its philosophy is reflected in the undergraduate and postgraduate curricula to which practitioners have been exposed. It remains regrettably true that, in spite of a number of brave experiments, medical and nursing education – it is probably less true of social work education – continue to be excessively committed to passive rather than active learning, usually on a monodisciplinary basis. The health care services in which the consumers are employed all too often given little encouragement to personal learning and sometimes indeed are structured in such a way as to breed a cynicism which is ultimately destructive of the professional ethos. In addition, health administrations, like many educational institutions, often do not appreciate the importance of identifying and remedying educational deficiencies and uncritically accept inappropriate solutions offered by teachers and teaching institutions.

These negative features are by no means universal. The attempts that have been made, often in the face of major obstacles, to develop imaginative curricula and encourage active and open learning must be saluted and their example widely commended. Some health services have learned to foster professional growth and have been able, as a result, to improve standards of health care and to stimulate a demand for continuing education. To the extent that more traditional attitudes and practices predominate, and communication between health care and education systems is inadequate, the environment in which continuing education is offered and received is bound to fall short of the ideal. However, those responsible for continuing education, whether as educators or health administrators, cannot wait for an educational and organizational millenium, but must develop the most effective plans and programmes possible while working at the same time for change and reform in other sectors.

Making effective plans means, among other things, building up relevant skills. In higher education generally – with the honourable exception of nursing – there is little or no tradition of preparing educational planners or teachers for the practice of their craft. An advanced knowledge of the subject is usually taken to be a sufficient criterion of suitability. It is perhaps paradoxical that a case for the specialist training in educational science of teachers should have to be made at what is in one sense the most advanced level of education, that of courses for qualified and experienced practitioners. At this level, however, we can least of all take it for granted that those who have most to contribute from their specialized understanding of technical and professional problems are necessarily competent to cope with all the demands of the educational task or even to appreciate the nature and scope of educational management and planning.

It would not be realistic to suggest that everyone contributing to continuing education should receive prolonged formal training in educational methods. As many as possible of those who organize and teach in continuing education programmes should, however, become skilled in identifying the educational needs of health services and of health workers, and in facilitating learning. Centres with a substantial commitment to continuing education should include in their staffs at least one or two experts in the art and science of education, so that they can work with physicians or other specialist colleagues in the improvement of methods of educational planning, teaching, learning and evaluation.

8. RECOMMENDATIONS

In concluding its task, the Working Group reviewed the specific recommendations made to the World Health Organization in 1973 by the Expert Committee on Continuing Education for Physicians. The Working Group was of the opinion that these recommendations remained valid, and wholly relevant to its objectives. It was noted also that, in spite of the narrower remit of the Expert Committee, its recommendations had clearly referred to health professionals in general and not only to physicians. In giving its own endorsement to those recommendations, the Working Group wished to set them out in full, as follows.

"...the World Health Organization should encourage and support the following activities.

1. The development of national systems of continuing education for the health professions with clearly defined central and regional administrative responsibility and authority, and the integration of such programmes with the national health care system.

2. The development of mechanisms for determining the local health needs and the deficiencies of practitioners in order to provide the basic data required for establishing priorities in the planning of continuing education programmes.

3. The identification and development of more realistic incentives and rewards for physicians to encourage them to engage in continuing education.

4. The development of discussion among specialists in health services, biomedical and social sciences, and professional education, with the purpose of delineating jointly the specific objectives and the processes of continuing education for the health professions.

5. The development of demonstration projects in interprofessional education.

6. The training of a corps of specialists in continuing education for the health professions who can provide national and local leadership for programmes in this field.

7. The further involvement of universities and medical schools in continuing education activities.

8. The development of practical and economical self-evaluation methods to assess the elements of professional competence.

9. The further development of materials for self-instruction that aim at increasing competence in managing (rather than merely understanding) the main health problems in Member States.

10. The development of the idea that the primary purpose of continuing education is to assist in the maintenance and improvement of competence in delivering preventive and curative health care not merely to impart knowledge and to spread information."[a]

The Working Group, in noting the continuing validity of these recommendations, also expressed its regret at the limited progress that had been made in putting them into effect since they were formulated in 1973. The establishment of the free movement of health professionals within the countries of the European Economic Community gave an added urgency to these recommendations.

The following additional recommendations were made.

11. There should be established within the European Region one or more centres for health manpower development.

12. A standing steering or advisory group should be set up to keep under review developments taking place between the meeting of this Working Group and that of its successor in 1978.

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[a] WHO Technical Report Series, No. 534, 1973, p.30 *(Continuing education for physicians)*

Annex

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